

Nevada Medicaid News

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First Health
Services Corporation®

A Coventry Health Care Company

Nevada Medicaid and Nevada Check Up
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Medicare Part D Prescription Program begins January 2006

Federal laws broadly known as the Medicare Modernization Act (MMA) (Public Law 108-173) have created a Medicare prescription drug insurance plan and removed duplicate drug coverage from Medicaid. Nevada Medicaid will comply with the MMA by no longer paying for the majority of medications for Nevada Medicaid recipients eligible for both Medicaid and Medicare benefits (dual-eligible recipients).

Effective Jan. 1, 2006, dual-eligible recipients will receive prescription drug coverage through a Medicare Part D Prescription Drug Plan (PDP) or Medicare Advantage Plan.

Nevada's dual-eligible recipients are receiving information regarding Medicare Part D from state and federal sources. The Nevada Division of Health Care Financing and Policy (DHCFP) is mailing letters of explanation to dual-eligible recipients. The Centers for Medicare & Medicaid Services (CMS) is mailing a notification as well as an informational handbook titled "Medicare & You 2006" to Medicare recipients.

Dual-eligible recipients who do not choose a PDP or Medicare Advantage Plan by the end of the year will be auto-enrolled in one of several available PDPs providing service in Nevada.

Please be advised that as a result of the changeover, drugs that a Medicaid recipient is now receiving may either not be covered by his/her new Medicare prescription drug plan or may require prior authorization. The prescriber may contact the recipient's Medicare drug plan with questions regarding drug coverage or consult the Formulary Finder on the CMS website at <http://plancompare.medicare.gov/formularyfinder/drugSelect.asp>

Prescription co-payments for non-institutionalized dual eligibles will now be required (\$1 for generics, \$3 for brands). These should be billed to Medicaid via the First Health Services Point of Sale (POS) system.

For dual-eligible recipients, Nevada Medicaid will continue to pay for the following types of drugs that, in most cases, will not be covered by their Medicare drug plan:

- ◆ Over-the-counter medications (such as Benadryl, Colace, Senokot and Tylenol)
- ◆ Vitamins and pre-natal vitamins
- ◆ Barbiturates (such as Phenobarbital)
- ◆ Cough and cold preparations

- ◆ Benzodiazepines (such as Ativan, Xanax, Valium and Restoril)

More information is available for providers at the following two webpages on the CMS website: <http://www.cms.hhs.gov/medicarereform> and <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>

If recipients have questions about the new coverage, you may refer them to (800) 633-4227 (TTY 877-486-2048); to the website: <http://www.medicare.gov>; to the Division of Aging Services' State Health Insurance Assistance Program (SHIP) at (800) 307-4444 (or in Las Vegas 486-3478); or to the Senior Rx Medicare Help Line at (866) 323-5953.

New Procedures for Billing with Third Party Liability

The Nevada Division of Health Care Financing and Policy (DHCFP) and First Health Services have revised billing procedures to alleviate adjudication problems on claims with Third Party Liability (TPL). Providers are required to include all TPL payments when billing Nevada Medicaid and Nevada Check Up.

New instructions have been created for ADA (dental), CMS-1500 and UB-92 claim forms submitted with TPL. Providers who bill using CMS-1500 and UB-92 forms will be notified through Web Announcements and Remittance Advice messages when the new instructions for claims with TPL are posted on the First Health Services website at <https://medicaid.nv.gov> (select "Billing Manuals" from the "Providers" drop-down menu). Revised billing instructions are currently posted for ADA claim forms. Please review the complete billing procedures.

Effective dates for the new billing procedures are:

- ◆ ADA claim forms – November 18, 2005
- ◆ CMS-1500 claim forms – January 13, 2006
- ◆ UB-92 claim forms – February 24, 2006

Beginning on the above effective dates, if TPL billing procedures are not followed claims will not be adjudicated properly and can result in denials.

For any questions regarding billing procedures, please call First Health Services' Customer Service Center at (877) 638-3472.

Save Time and Money with Electronic Remittance Advices

For each week in which Nevada Medicaid and Nevada Check Up providers have claims activity, First Health Services sends to them a Remittance Advice (RA) reporting the adjudication of claims submitted. Unless otherwise specified, a paper RA is mailed to providers.

Providers can save both time and money by requesting to have their RAs transmitted to them electronically. Time and operational costs are saved by removing the wait time for paper RAs to arrive through the mail and eliminating the task of posting the claims into a Practice Management System. Providers who receive an Electronic Remittance Advice (ERA) are able to import the RA file; the payment details are then posted to account receivables.

The 835 Health Care Claim Payment Advice Transaction (835 ERA) is an electronic Explanation of Benefits (EOB) detailing services being paid, services not being paid and reasons for each with edit codes specified. Some clearinghouses offer providers the option of accepting and processing electronic data transfers, such as the 835 ERA. An additional benefit to the 835 ERA is that, when the situation warrants, First Health Services sends an unsolicited Claims Status Response Transaction (277u) to notify providers when claims have pended.

To receive an electronic remittance advice, contact your clearinghouse or if you aren't set up with a clearinghouse contact your software vendor for setup recommendations. You will need to submit to First Health Services form FH-37 (Service Center Authorization Form for Providers) to authorize your service center to receive and process your ERA. FH-37 is available online; select "Electronic Claims/EDI" or "Forms" from the "Providers" drop-down menu at <https://medicaid.nv.gov>. Mailing instructions are on the form.



The Companion Guide for Transaction 835 Remittance Advice provides software vendors with technical specifications. The Guide is posted under EDI Companion Guides on the "Electronic Claims/EDI" webpage at <https://medicaid.nv.gov>.

Please note that consent to an ERA does not authorize electronic transfer of claims payment. If you are interested in completing the electronic loop, you may authorize First Health Services to directly deposit electronic payments into your bank account. Funds will be received faster since they will be transferred into your bank account rather than mailed in check form. To start this process, you will need to complete and submit form FH-32 Electronic Funds Transfer (EFT) Agreement (for the form and instructions select "Forms" from the "Providers" drop-down menu at <https://medicaid.nv.gov>).

For questions regarding EFT, contact First Health Services' Provider Enrollment Unit by e-mailing nevadamedicaid@fhsc.com or by calling (877) 638-3472. Providers do not have to receive ERAs in order to request EFT.

For more information regarding ERAs, contact the First Health Services EDI Coordinator by e-mailing nvedi@fhsc.com or by calling (877) 638-3472.

PA and PCA News Items

New Policy Chapter for Personal Care Services:

Chapter 3500-Personal Care Aide Program (PCA) of the Division of Health Care Financing and Policy's Medicaid Services Manual (MSM) became effective June 29, 2005. To review the new Chapter online visit <https://medicaid.nv.gov>. Select "DHC FP Web Site" from the "Quick Links" drop-down menu; click on "Medicaid Service Manuals" then click on "Chapter" under 3500-Personal Care Aide Program (PCA).

Per Chapter 3500 Section 3503.1D.1.a of the MSM, the provider agency can no longer make initial requests for services or request an authorization to transfer services for a recipient who is

currently on service, but new to the agency. The chapter states that a request can be made by the recipient, a legally responsible adult, personal care representative, or individuals covered under the confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Therefore, First Health Services will no longer accept requests for initial assessments or to transfer a recipient for services unless a HIPAA-compliant consent form is attached to the prior authorization request.

Reminder for Dental Providers:

A prior authorization (PA) is not required for dentures and partials. Section 1003.5.A.1 of Chapter 1000-Dental Services of the Division of Health Care Financing and Policy's Medicaid Services Manual (MSM) states the following policy:

Partial dentures and full dentures may be provided when necessary to prevent the progression of weight loss and promote adequate mastication. Medicaid will pay for replacement of dentures or partials no more than once every 5 years, when medically necessary.

Recipients are not eligible for dentures following a partial, unless 5 years have lapsed from the date of service the partial was billed and paid for.

Providers may call (800) 648-7593, ext. 2 (Dental) to review a recipient's history to see if Nevada Medicaid has paid for either a partial or a denture in the last 5 years.

Medicare Exhausted Benefits in the PA Process:

For paper Prior Authorization (PA) requests: If the recipient's Medicare benefits (Part A, Part B or both) have been exhausted, providers must attach to the PA request a Medicare Catastrophic Coverage Act (MECCA or MCCA) form or the Medicare Explanation of Benefits (MEOB). If a MECCA or MEOB is not available, call (800) 525-2395 before submitting the PA request.

For PA requests using the Online Prior Authorization System (OPAS): If the recipient's Medicare benefits (Part A, Part B or both) have been exhausted, in addition to submitting a PA request through OPAS please fax the MECCA form or the MEOB to (866) 480-9903. Please note on the PA review that "MECCA or MEOB was faxed" and note the PA Request ID Number on the fax. For information regarding OPAS, go to <https://medicaid.nv.gov> (select "Prior Authorization" from the "Providers" drop-down menu, and click on the "Online Prior Authorization System" link).

Reminder: Prior Authorization is not a guarantee of payment.

Provider Responsibility to Verify Recipient Eligibility

Providers must always verify a recipient's Nevada Medicaid and Nevada Check Up eligibility benefits before rendering services.

The recipient's plastic Nevada Medicaid and Nevada Check Up identification card does not guarantee eligibility and does not contain eligibility data. The card, which shows the recipient's 11-digit billing number, last name, first name, sex and birthday, is used for identification purposes only.

Information regarding the category of eligibility, managed care, recipient restrictions and Third Party Liability is accessible through the following sources:

- ◆ First Health Services' Electronic Verification System (EVS) – log on to <https://medicaid.nv.gov>. From the “Providers” drop-down menu select “EVS Logon” or “EVS User Manual.”
- ◆ A swipe card system – contact your swipe card vendor for details.
- ◆ The Nevada Medicaid Audio Response System (ARS) – call (800) 942-6511.

For specific details on how to determine a recipient's Health Maintenance Organization (HMO) enrollment when you access EVS, please refer to the article titled “Verify Recipient Eligibility and Benefit Plans on a Monthly Basis” in the Summer 2005 issue of Nevada Medicaid News. The provider newsletter is available online at <https://medicaid.nv.gov> (select “Announcements/Newsletters” from the “Providers” drop-down menu, then click on “Summer 2005 Newsletter”).

Notification of Public Hearings Regarding Medicaid Policy Changes

The State of Nevada Department of Human Resources' Division of Health Care Financing and Policy (DHCFP) holds public hearings to discuss proposed changes regarding Nevada Medicaid and Nevada Check Up policy.

Providers may request to be notified of the hearings by contacting Nancy Davis at DHCFP. Call (775) 684-3715 or e-mail her at ndavis@dhcfp.state.nv.us and ask to receive the notifications by regular mail or e-mail.

Public notices are posted on the DHCFP's Nevada Medicaid website (at <https://medicaid.nv.gov> select “DHCFP Web Site” from the “Quick Links” drop-down menu; select “DHCFP Homepage”; then click on “Public Notices” from the menu on the left side of the webpage).

Your Options When a Claim Has Been Denied

If you do not agree with the denial of a claim, please contact a First Health Services Customer Service Representative (CSR). A CSR may be able to identify and resolve the issue over the phone, or direct you on possible resubmission options so the claim can be re-evaluated for payment determination.

Providers have the option to appeal a claim that has been denied. **Appeals must be postmarked no later than 30 days from the date on the Remittance Advice (RA) showing the claim as denied.** For complete instructions on how to file an appeal, see the "Appeals" sections of the Provider Billing Manuals posted under "Providers" at <https://medicaid.nv.gov>.

A claim that was paid incorrectly cannot be appealed. If a claim was paid incorrectly, request an adjustment as described in the Provider Billing Manuals.

If you have any questions regarding the adjudication of your claims, please call First Health Services at (877) 638-3472.

Quarterly Update on Claims Paid

The Nevada Medicaid program paid out to providers more than \$259,552,528.42 in claims during the three-month period of July, August and September 2005. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

The Nevada Division of Health Care Financing and Policy and First Health Services thank you for participating in Nevada Medicaid and Nevada Check Up.

CONTACT INFORMATION

If you have a question on Claims Payment, please contact First Health Services Corporation by calling (877) 638-3472 or e-mailing nevadamedicaid@fhsc.com

If you have questions about Medicaid Service Policy or Rates, you can go the Division of Health Care Financing and Policy (DHCFP) website: www.dhcfp.state.nv.us and look for the item labeled: CONTACT INFORMATION. Move your cursor to that item and follow the directions to find the person at DHCFP who can answer your question. You can either phone the contact person or send an e-mail.